BRIAN SANDOVAL
Governor

RICHARD WHITLEY, MS
Director

MARTA JENSEN
Acting Administrator

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DRAFT MCAC MEETING MINUTES

Date and Time of Meeting:	July 19, 2016 at 10:02AM
Place of meeting:	Nevada State Legislature Building 401 S. Carson Street, Room 2134 Carson City, Nevada 89701
Place of Video Conference:	Grant Sawyer Office Building 555 E. Washington Avenue, Suite 4406 Las Vegas, Nevada 89101
Teleconference:	(877) 402-9753
Access Code:	7316372

Attendees

Board Members (Present)
David Fluitt, Vice Chairperson
Peggy Epidendio, Board Member
Tracey Green, Board Member
June Cartino, Board Member
John DiMuro, Board Member

Board Members (Absent)
Rota Rosaschi, Chairperson
David Fiore, Board Member
Ryan Murphy, Board Member

Carson City
Darrell Faircloth, Senior DAG
Scott Mayne, Washoe County / Carson City
Laura Hale, DPBH/PCO
Samantha Sweeney, Otsuka
Jennifer Lauper, BMS
Lisa Mantkus, HPN
Theresa Fanna, HPN
Allyson Hoover, Amerigroup
Rachel Marchetti, DHCFP
Angela Bredencamp, HPN
Mark Schwarti, GSK
Cheri Glockner, HCGP
Bill Torch, NDC/WSDC
Lea Cartwright, NPA
Rachel Rosensteel, HPN
Christina Galan, HPN
Emma Kibisu, Amerigroup
Gladys Cook, DHCFP
Tracy Palmer, DHCFP
Kim Gahagan, HPN

Mike Easterday, Aetna
Tiffany Lewis, DHCFP
Lynne Foster, DHCFP
Jennifer Frischmann, DHCFP
Rosanne Hoff, DHCFP
Shannon Sprout, DHCFP
Thomas McCrorey, HCGP
Marta Jensen, DHCFP
Kim Riggs, DHCFP

Las Vegas
William Sanders, Public

Teleconference
Jasmine Holden, Royal Springs HC & Rehab Center

I Call to Order

Vice Chairperson Fluitt called the meeting to order at 10.00 AM.

II Introduction of New Members

Vice Chairperson Fluitt introduced the three new members, Ms. June Cartino, Dr. John DiMuro and Dr. Tracey Green.

Ms. Cartino stated that she has been at TLC Care Center, Henderson, Nevada for a year. She said that she has been in healthcare since 1998 as a nurse with a background in case management, admissions and nursing home administration.

Dr. DiMuro said that he is the new Chief Medical Officer starting July 1, 2016. He said he has been in private practice in pain management for 12 years. He also stated that he is dual-board certified in anesthesiology and pain medicine.

III Roll Call

Vice Chairperson Fluitt asked for roll call. A quorum was established. Vice Chairperson Fluitt stated that this was properly posted and it does meet the open meeting laws.

IV Public Comment on Any Matter on the Agenda

Dr. Torch introduced himself as a board-certified child and adult neurologist, the Director of the Washoe Sleep Disorder Center and the Medical Director of the Neurodevelopmental Diagnostic Center which he has managed since 1983. Dr. Torch stated that he will be retiring and he is concerned about his patients, most of whom are Medicaid recipients, Health Plan of Nevada (HPN) or Amerigroup recipients. He said he is faced with a dilemma of helping his patients get adequate care upon his retirement. He is concerned that there is not adequate coverage in Northern Nevada, and Medicaid would rather send the children to Las Vegas instead of to UC Davis, which is closer.

Vice Chairperson Fluitt thanked Dr. Torch for his comments and concerns and told him that Laura Hale would be a good person of contact.

V For Possible Action: Review and Approve Meeting Minutes from April 19, 2016 (See Attachments)

The minutes from April 19, 20616 were approved as written.

VI Administrator's Report, Presentation of State Plan Amendments (SPA) and Medicaid Services Manual (MSM) Updates by Marta Jensen, Acting Administrator for the Division of Health Care Financing and Policy (DHCFP)

Ms. Jensen said the DHCFP has been in a lot of meetings with providers trying to find out from the provider perspective where the Division stands. She said it all started with the Managed Care Expansion Project but they have ended up being an "all-comers" where everybody could come and comment. The DHCFP used this information when developing the budget to put forth recommendations to the Director and Governor.

Ms. Jensen also reported that there is a Request for Proposal (RFP) in place for managed care services beginning July 1, 2017. The RFP is in the questions and responses period, with the evaluation expected towards the end of August.

Ms. Jensen continued with the Managed Care Expansion Project by saying that in the last legislative session, it was asked that the DHCFP incorporate Long Term Services and Support (LTSS), which is currently a carve-out service, into the managed care contract. The director at the time thought this was a good opportunity to look at all carve-out services and managed care as a whole. Managed care has been in place since 2000 and the Division is determining if this model is working or if it needs to be improved. She pointed out that managed care is only in Washoe and Clark Counties and the Division is evaluating carving additional populations or geographical areas.

Ms. Jensen stated that the DHCFP is also looking at a Dental Managed Care plan. The Division is looking at having an RFP in the next 60 – 90 days.

Ms. Jensen mentioned that the DHCFP changed Third Party Liability (TPL) vendors. As of July 1, 2016, Hewlett Packard Enterprises Services (HPES) contracted with a new vendor, Health Management Systems (HMS), with whom we have done business with before. HMS is tasked with finding out if there is other insurance coverage for Medicaid recipients, which would be primary.

Ms. Jensen also reported on revalidation. Revalidation is mandated through the Affordable Care Act (ACA). She said that all providers who enroll with Medicaid are required to revalidate their information at least once every five years. All providers are required to be revalidated by September 23, 2016. After a lot of outreach by the Division, only about 2,200 providers out of approximately 27,000 which have not revalidated. Those 2,200 will have to be terminated per the ACA. The Division is trying to determine why these 2,200 have not revalidated.

Ms. Jensen talked about an ongoing project of looking at all of the DHCFP's policies. With regard to the Medicaid expansion, we have doubled in size. She went on to state that in December 2013 we had 323,000 recipients. As of July 2016, we have 655,000 recipients. The Division is looking at the policies to make sure they are efficient, effective and that they are meeting the goal of

preventative and early intervention care. With limited funds, the division is streamlining policies and procedures for timely service delivery.

Ms. Jensen reported on the SPAs submitted to the Centers for Medicare and Medicaid Services (CMS). Ms. Jensen also covered the MSM updates. See attached report.

Ms. Epidendio requested more information on the homeless population and working with the Governor's Interagency Council that Ms. Betsy Aiello reported on last meeting. She commented that so many of the homeless population have a hard time getting home healthcare services and that the DHCFP was going to look into the possibility of funding.

Ms. Jensen replied that she had no further information but that we could put it on the agenda for the next meeting.

Dr. Green inquired about revalidation, and its effect on access to care.

Ms. Jensen responded that the Division can survey the provider population. Currently, the procedure is that providers are responsible for updating their information with regard to whether they are accepting new patients or not. The Division would like to have a system put in place where the providers can enter in their demographic information.

Dr. Green commented that the revalidation process is an opportunity since everybody will be re-enrolling. Dr. Green also questioned about the direct enrollment. She wanted to know if that will include presumptive.

Ms. Sprout answered that her unit, the Clinical Policy Team, is in process of making a policy change to MSM Chapter 100 – Medicaid Program that will include provisional licensure for those professionals that are licensed in another state. This should help move the credentialing process along.

Dr. Green reiterated that she was asking about direct enrollment. She asked if the hospitals that are doing presumptive eligibility be able to enroll directly into managed care.

Ms. Sprout replied that she doesn't see any challenges with that, but her unit could do some research and give Dr. Green a more specific answer.

Ms. Holden made the comment that in regard to the Managed Care Organizations (MCOs) and eligibility, knowing that you are between the ages of 18 and 64 and you qualify for Medicaid, under the Childless Adult category, when you submit a Medicaid application, the month that you are deemed eligible for Medicaid you are given Fee-for-Service (FFS), then effective the first of the following month you are assigned an MCO. If the person is in a skilled nursing facility, they have 45 days of benefits, then it flips to FFS. If the person goes to the hospital, then returns to the Nursing Facility (NF), the recipient is automatically enrolled in MCO after the first of the next month. As a NF, they are required to check eligibility once a month, however, it is difficult to keep on top of who has FFS or MCO. Ms. Holden is glad that something is being done with CMS about this. Ms. Holden also commented that from a specialized provider point of view, there are a lot of problems when getting a person deemed competent to be safely discharged back into the community. Ms. Holden requested that the DHCFP look into it in regard to the MCOs. Ms. Holden

went on to comment about discharges. She said that most of the residents that are assigned to an MCO are high functioning. They can be safely discharged to a lower level of caring, however, they have no source of income. She requested that the state look into this problem also.

Ms. Frischmann replied that her unit can get her in touch with the Money Follows the Person (MFP) program and their Facility Outreach and Community Integration Services (FOCIS) program which helps transition people out of Skilled Nursing Facilities and back into the community.

Ms. Holden stated that she has dealt with the FOCIS program. She said that she is hoping to work together with the DHCFP as a team in order to expedite the process.

VII Updates on Behavioral Health Professional Pipeline Mapping and Recommendations to DHCFP
By Laura Hale, Primary Care Workforce Development Office

Due to current updates, this report was delayed until the next meeting

VIII Discussion on Managed Care Quality and Challenges

- **Amerigroup - Emma Kibisu, Director of Quality Management and Allyson Hoover, Director of Provider Services and Provider Solutions (see attached presentation)**

  Vice Chairperson Fluitt stated that he is familiar with long acting antipsychotic medications and their impact on the community and he would like to know about accessibility to care and if their team is measuring the outcomes. He would like Amerigroup to provide a report on how successful they are.

  Ms. Hoover replied that the accessibility to their vendor for behavioral health wrap-around services has grown exponentially. She stated that they have over 2,600 people that have been impacted since August 2015. Ms. Hoover informed the board that all those people are enrolled. They will see a psychiatrist and a primary care physician (PCP) as needed. Amerigroup also has about 180 people in short-term housing and long-term housing. This housing is for people who need short-term crisis interventions.

  Dr. Green thanked them for all the work they are doing. She wanted to know if Amerigroup is co-occurring capable. She also inquired about Medication Assisted Treatment (MAT) and the availability of providers.

  Ms. Hoover replied that Well Care's core competency is pharmacy and bedside delivery. Every member receives medications at the time of discharge. She said that one of the problems is that the member may end up losing their medications. One of the upsides is that Well Care will be able to provide the medication at a shelter or at a home.

  Dr. Green said that MAT is relevant to specific medications for individuals that are suffering from substance abuse disorder. She believes this is an area that these individuals who are in recovery mode need supportive drugs.

  Ms. Hoover replied that she would like to meet with Dr. Green and discuss that further.

- **Health Plan of Nevada (HPN) - Angela Bredenkamp, Associate Director of Clinical Quality (see attached presentation)**

Ms. Holden requested more information about the Willing Hands program.

Ms. Bredenkamp replied that it is an 11-bed stabilization unit that is set up for the people that are homeless and not able to go immediately back to their homeless setting. But they are not eligible for a Skilled Nursing Facility stay. They are in-between the two levels of care. They typically need home health care and it is a good opportunity to do a wrap-around service.

Ms. Holden asked if the case managers are aware of the program and if she could get contact information.

Ms. Bredenkamp replied that the case managers should know about the program, currently only in the Las Vegas area. She said she would supply Ms. Holden with her name and phone number.

Ms. Bredenkamp continued with her presentation.

Vice Chairperson Fluitt commented that there seems to be a predominance of subscribers in the southern Nevada area and asked why that is and why things are just getting initiated in northern Nevada.

Ms. Bredenkamp asked if he was looking for provider or member initiatives information.

Vice Chairperson Fluitt replied that he is looking for information on both as a package with regards to accessibility. He indicated the appearance of well-developed program in southern Nevada and asked for the reasons behind that.

Ms. Bredenkamp responded that they can still keep focus on southern Nevada but northern Nevada has been their key area of focus within the last couple of years. HPN now has local staff that is working out in the community. They want the northern Nevada members to feel like they are getting the same benefits as the southern Nevada members. They have more ability in southern Nevada to test things to see how they work and if they are successful, they can roll it up to northern Nevada.

Vice Chairperson Fluitt said that he is looking for quality indicators and levels of satisfaction. It seems like HPN's initiative is to make sure they are going to their dental visits, whereas previously the board heard that HPN needed more dental access.

Ms. Bredenkamp replied that access to care is a concern for all of Nevada. HPN tries to incentivize new providers to come in and work with Medicaid members. She said it is something that they continue to focus on.

Vice Chairperson Fluitt stated that he would like to see more statistics. In the presentation Ms. Bredenkamp stated that they reduced readmissions by 72% and he would like to see the study base.

Dr. Green supported the Vice Chair in evaluating the data so the board can get a better idea on what kind of impact this is having. Dr. Green commented that it looks like the childhood immunization rates are going up and that access to primary care is still a challenge. She inquired if that was because immunizations are now available at the pharmacy as opposed to their PCP. Dr. Green also wanted to acknowledge the co-occurring population, such as those with a substance abuse disorder. She wanted to know if they would be moving in that direction in the future.

Ms. Bredenkamp responded that HPN tries to get the children immunized in as many ways possible, such as pharmacies, primary care and health fairs. She stated that as far as co-morbidity, they have focus groups that are evaluating what has been successful nationally and what they can implement here.

IX DHCFP Reports

- **Overview on Access to Care Monitoring Review Plan (see attached document)**
  By Tracy Palmer, Social Services Chief II, Managed Care & Quality

Ms. Palmer stated the Centers for Medicare and Medicaid Services (CMS) has recognized that access to care has been hit hard. She stated that the regulation has been in place a long time, but there are new rules and requirements that are resulting in a more transparent plan. Ms. Palmer wanted to ensure that everyone received a copy of the draft plan she composed. She stated that this will be a live, on-going document.

Ms. Palmer reported that in March 2015, the Supreme Court ruled that Medicaid's Equal Access Provision does not provide a private right of action for the providers or beneficiaries to challenge Medicaid's payment rates in federal court. She said that CMS realized that this would be a problem. CMS required Medicaid to develop and publish a rule implementing an Equal Access Provision that requires state Medicaid agencies to develop a Medical Assistance Access Monitoring Review Plan. CMS wants states to become more transparent and the Division needs to consider input of the community and stakeholders. This plan considers access to care, availability of providers and geographic concerns. The rule requires that the Medicaid agencies develop, update, publish and submit to CMS the Medicaid Access Monitoring Review Plan. It also requires that the DHCFP analyzes the data before any changes can be made.

Ms. Palmer reiterated that this is a living document. It will expand, change and be updated every year. This plan focuses on five core measures which can be added to. The core areas are primary care services, physician specialist services, behavioral health services, pre- and post-natal obstetrical services, home health services or any other services that impacts the volume of complaints from providers and recipients. She mentioned that this plan is due October 1, 2016. CMS is requiring a corrective action plan in which the state will do a revision that will be transparent. Ms. Palmer wanted to point out that there is a featured link called Nevada's Access to Care Plan on the DHCFP website. When you click on it,

you will be directed to the Executive Summary and a copy of the Draft Document. Ms. Palmer encouraged any comments or feedback.

Vice Chairperson Fluitt stated that it looks very transparent. He said that the appointment availability numbers caught his eye. People who can make appointments versus the ones who cannot. Vice Chairperson Fluitt wanted to know what was Ms. Palmer's mechanism of feedback. He questioned if she gets most of her feedback on levels of satisfaction from recipients and providers from the Nevada's Access to Care Plan link.

Ms. Palmer replied that she has been doing presentations, talking to different groups, sister agencies and the Tribal Council. She stated that she has been talking with different states also. She takes feedback, comments and suggestions by email, phone or in writing.

Vice Chairperson Fluitt questioned how the committee can be informed of the initiatives and what progress is done up to the submission date.

Ms. Palmer responded that the next MCAC meeting will be after the submission date. Ms. Palmer said that she is open to sending them the next revised Draft Document after she receives more feedback or they are welcome to call or email for and update. She said she would also send them the Final Draft Document when available.

- **Discussion on Changes to the Hospice Program**
  By Jennifer Frischmann, Chief of Long Term Services and Support and Rosanne Hoff, Health Care Coordinator III, Long Term Services and Support

Ms. Frischmann stated that the changes to the Hospice Program has been a long time in the making. She said that her unit has held multiple workshops and has received a lot of input from the hospice industry.

Ms. Hoff reported that hospice is available to all Medicaid recipients regardless of age. The only difference is that in pediatric care they are still able to receive aggressive treatment. She stated that Medicaid is becoming more aligned with Medicare and the Code of Federal Regulations (CFRs) as far as terminal diagnosis. Medicaid is going to follow Medicare's guidelines for non-cancer diagnosis determinations and the Local Coverage Determination (LCD) for hospice, especially for adults. She further stated that LCDs were not made for pediatrics, but the providers can still use those categories for their system assessments as guidelines for their narratives that come with their certification to say why the provider feels that the recipient has six months or less to live. Ms. Hoff stated that a lot of the diagnosis submitted are for palliative care program, which at this time, Medicaid does not have. The next item Ms. Hoff pointed out is that according to the CFR, the recipient must have a face-to-face encounter with a physician prior to the third certification period of hospice services. Nevada Medicaid will also require the recipient have a face-to-face with a physician within seven to ten days of admission to hospice.

Vice Chairperson Fluitt asked if that was an office visit or home visit.

Ms. Hoff replied that it could be anywhere.

Vice Chairperson Fluitt commented that this is a robust program and that respectful death is important and he is glad to see resources put into the program. He inquired if the state has enough providers.

Ms. Hoff affirmed that the state does.

Ms. Hoff went on to state that there are now standardized hospice forms, including adult and pediatric election forms. Previously, each hospice provider had their own forms. The forms delineate between what hospice providers and private duty nursing are responsible for so there is no overlapping of services. Ms. Hoff also stated that if a recipient is approaching a year in hospice, there will be an independent physician review for that recipient to determine if that physician agrees with the clinical diagnosis. She stated that hospice will now have to have a Prior Authorization (PA).

Vice Chairperson Fluitt asked how long does the PA process take.

Ms. Frischmann replied that the PA process will be done by the fiscal agent and the turnaround time is between three and five days. She clarified that currently there is an authorization process. In the past, providers supplied their own forms. Now with it being standardized, there will be a clinical review of the hospice diagnosis.

Dr. Green wanted to thank Ms. Frischmann and Ms. Hoff for all their work. Compassion and passionate care is very important.

Ms. Holden inquired to the face-to-face done within seven to ten days of admission to the hospice program in a skilled nursing facility, can it be done by either the primary care physician that is assigned to the resident or the medical doctors from the hospice company.

Ms. Hoff replied that the face-to-face can be done by any physician or advanced practice nurse under that physician's guidance.

Ms. Holden asked if at the one year review, would it be someone through the fiscal agent looking at the documents to see if they still meet the criteria.

Ms. Hoff replied that she is correct.

Vice Chairperson Fluitt requested that Ms. Holden reach out to the staff in a different manner as these questions and comments are reserved for committee members only.

- **Presentation and Progress Update on National Governor's Association (NGA) Behavioral Health in Youth Transformation**
  By Kim Riggs, SSPS II, Outpatient Behavioral Health, Clinical Policy Team

Ms. Riggs reported that the NGA has allowed the DHCFP to transform youth behavioral health in Nevada. She said this service will provide preventative services within our community. The Division is looking at new ways for children to obtain these services prior to a crisis. The proposed model will revise the Children's Insurance Health Program (CHIP). It will benefit services to the state plan, including the Resources for the Early

Advancement of Child Health (REACH) program. The program will be piloted from Carson City. An evidenced based curriculum will be put into place within in the Boys and Girls Club.

Ms. Riggs said that the DHCFP has been working with the Division of Child and Family Services (DCFS), the Division of Public and Behavior Health (DPBH) and the Department of Education (DOE). Ms. Riggs pointed out that you can go to the DOE's website and click on the Climate Survey which evaluates all schools within the State of Nevada. This survey gives a guideline as to which schools are at risk. Her unit evaluated the data and determined outreach needs in rural areas. They reached out to the Carson City School District and they helped to identify the low income schools in the area. Within the REACH program will be a package that will be a six week course. It will have two age cohorts, ages 10 – 12 and ages 13 – 17. She said that these services have transformed from being a Section 1115 Waiver to a CHIP initiative. Ms. Riggs stated that the REACH program provides coordinated services, prioritizing community integration, health literature support, vocational supports, recreational supports, family need assessments, positive youth development, the opportunity to enhance and maintain skills, coping skills, accessibility, and competency in social and academic settings. Parent coaching will also be included in this program. She indicated a focus on multi-family participants. The basis of the coverage will have pre-imposed testing. Ms. Riggs said that they are looking at Healthy Choices to plug in some other services to make sure that they are covering what the individual child needs within society.

Ms. Epidendio requested the age ranges again.

Ms. Riggs replied that the original age was seventh grade. But it was indicated that the division should reach down lower so the ages are now 10 – 12 and 13 – 18.

Ms. Epidendio inquired if after the first year of evaluation, would they be able to identify if there would be a need for this at a younger age. Because there are so many younger children that have issues that need to be addressed.

Ms. Riggs replied absolutely. She said that is something they will be looking at with the pre- and post-data. Ms. Riggs is in agreement that the younger, the better. She reported that currently the program is going through the Division's internal approval process and will be going to public hearing on September 8, 2016.

Dr. DiMuro wanted to know what the most common diagnosis is.

Ms. Riggs responded that these are preventative services so they are looking at non-diagnosis. Identifying needs and referrals to other services is a focus.

Dr. Green wanted to thank Ms. Riggs and her team. She asked if they will be continuing to use the child and adolescent needs and strengths (CANS) in the pre- and post-testing.

Ms. Sprout replied that due to the challenges of what the requirement would be, because they would be pre-diagnosis, the Division had to move it into the CHIP funding for the administrative funding. When that was done, it changed the scope on how it would be

administered. It took away components of the CANS and is replacing that with the population health project. The curriculum that's identified will have a pre-imposed testing. The CANS won't be a component of the services, it will be provided by the recreation program that is selected. It is still being evaluated by the DCFS. The DCFS will bring the CANS in to do an evaluation so the DHCFP can use them as part of the outcome measures. It is still undecided where the CANS will be, but it will be outside of this project.

Dr. Green wanted to confirm that the pre- and post-testing will be based on the program selected for REACH.

Ms. Sprout affirmed that. She stated that the DHCFP has been working with the DPBH and the DCFS to identify the evidence base curriculum that the selected school program will use. At this point in time, it is still being evaluated.

Vice Chairperson Fluitt wanted to thank them for the work they are doing with this program and their commitment to the agency. Speaking as a resident of Carson City, he is happy to see this project here. He also stated that he is excited to see the reports.

X Public Comment on Any Topic

Dr. Torch congratulated the committee on the presentation. He stated that he started out talking about his own issues trying to find access of care for his patients. He would like to congratulate Amerigroup and HPN for their new approaches to access to care. One thing that was missing today, except briefly touched upon by Ms. Riggs, is prevention. He wanted to emphasize the concept "an ounce of prevention is worth a pound of cure," and provided examples from his experience supporting that. Dr. Torch said he has ten items that need to be addressed.

Vice Chairperson Fluitt requested that Dr. Torch keep the rest of his comments brief since the meeting has run longer than anticipated.

Dr. Torch summarized the items as being child abuse, methamphetamine issues, use of drugs, neonatal exposure, mental health counselling, sleep and sleep apnea, obesity and its relationship to ADD, use of drugs including Ritalin and stimulants, pregnancy in girls with no fathers to help take care of the children, comorbidity – methamphetamine and alcohol exposure in children.

Vice Chairperson Fluitt thanked Dr. Torch for his comments and for everything he has committed to the state in his practice of 35 years.

Dr. Torch went through a summary of his background and credentials for 38 years.

Vice Chairperson Fluitt said that we are looking at integrating prevention into our health care system.

Dr. Green commented that it will be a huge loss when Dr. Torch retires.

XI Adjournment

Vice Chairperson Fluitt adjourned the meeting at 11:49AM